

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0028472</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER														
Facility Name: <u>THREE SPRINGS LODGE NURSING HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.														
Address: <u>161 THREE SPRINGS ROAD</u> <u>CHESTER</u> <u>62233</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.														
County: <u>RANDOLPH</u>																
Telephone Number: <u>(618)826-3210</u> Fax # <u>(618)826-3821</u>																
IDPA ID Number: <u>371140355001</u>																
Date of Initial License for Current Owners: <u>08/01/72</u>																
Type of Ownership:																
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY														
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual														
<input type="checkbox"/> Trust		<input type="checkbox"/> State														
IRS Exemption Code _____		<input type="checkbox"/> Partnership														
		<input checked="" type="checkbox"/> Corporation														
		<input type="checkbox"/> "Sub-S" Corp.														
		<input type="checkbox"/> Limited Liability Co.														
		<input type="checkbox"/> Trust														
		<input type="checkbox"/> Other _____														
In the event there are further questions about this report, please contact: Name: <u>ROGER BAGLEY</u> Telephone Number: <u>(618)549-8331</u> <u>JAMESTOWN MANAGEMENT</u>		<table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Type or Print Name) <u>ROGER W. BAGLEY</u></td> </tr> <tr> <td>(Title) <u>CONTROLLER</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # ()</td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>ROGER W. BAGLEY</u>	(Title) <u>CONTROLLER</u>	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # ()
Officer or Administrator of Provider	(Signed) _____															
	(Date) _____															
Paid Preparer	(Type or Print Name) <u>ROGER W. BAGLEY</u>															
	(Title) <u>CONTROLLER</u>															
	(Signed) _____															
	(Date) _____															
	(Print Name and Title) _____															
	(Firm Name & Address) _____															
	(Telephone) <u>()</u> Fax # ()															
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630														

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME# 0028472 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>52</u>	Skilled (SNF)	<u>52</u>	<u>18,980</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>31</u>	Intermediate (ICF)	<u>31</u>	<u>11,315</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>83</u>	TOTALS	<u>83</u>	<u>30,295</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>587</u>	<u>587</u>	8
9	SNF/PED					9
10	ICF	<u>19,779</u>	<u>7,366</u>		<u>27,145</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,779</u>	<u>7,366</u>	<u>587</u>	<u>27,732</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.54%

D. How many bed-hold days during this year were paid by Public Aid?

88 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/01/72

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 18 and days of care provided 587Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOM** # **0028472** Report Period Beginning: **01/01/01** Ending: **12/31/01****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	132,953	5,990	5,900	144,843		144,843		144,843		1
2	Food Purchase		90,698		90,698	(6,339)	84,359	(249)	84,110		2
3	Housekeeping	73,598	8,814		82,412		82,412		82,412		3
4	Laundry	45,853	5,179		51,032		51,032		51,032		4
5	Heat and Other Utilities			62,738	62,738		62,738		62,738		5
6	Maintenance	23,041	19,982	32,950	75,973		75,973	769	76,742		6
7	Other (specify):*										7
8	TOTAL General Services	275,445	130,663	101,588	507,696	(6,339)	501,357	520	501,877		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	834,015	25,996	1,150	861,161	(3,490)	857,671		857,671		10
10a	Therapy	36,984		9,131	46,115		46,115		46,115		10a
11	Activities	39,467	2,234	2,160	43,861		43,861		43,861		11
12	Social Services	18,059		2,160	20,219		20,219		20,219		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	928,525	28,230	14,601	971,356	(3,490)	967,866		967,866		16
	C. General Administration										
17	Administrative	72,119			72,119		72,119		72,119		17
18	Directors Fees										18
19	Professional Services			135,638	135,638		135,638		135,638		19
20	Dues, Fees, Subscriptions & Promotions			5,957	5,957		5,957	(2,256)	3,701		20
21	Clerical & General Office Expenses	22,299	5,900	4,734	32,933		32,933	(414)	32,519		21
22	Employee Benefits & Payroll Taxes			141,639	141,639	45,056	186,695		186,695		22
23	Inservice Training & Education			857	857		857		857		23
24	Travel and Seminar			5,542	5,542		5,542		5,542		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			56,652	56,652	(35,227)	21,425		21,425		26
27	Other (specify):*										27
28	TOTAL General Administration	94,418	5,900	351,019	451,337	9,829	461,166	(2,670)	458,496		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,298,388	164,793	467,208	1,930,389		1,930,389	(2,150)	1,928,239		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME** #0028472 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,215	20,215		20,215	14,346	34,561			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							15,548	15,548			33
34	Rent-Facility & Grounds			252,000	252,000		252,000	(252,000)				34
35	Rent-Equipment & Vehicles			114	114		114		114			35
36	Other (specify):*											36
37	TOTAL Ownership			272,329	272,329		272,329	(222,106)	50,223			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,687	36,749	74,436		74,436		74,436			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,443	45,443		45,443		45,443			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		37,687	82,192	119,879		119,879		119,879			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,298,388	202,480	821,729	2,322,597		2,322,597	(224,256)	2,098,341			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME**# **0028472**Report Period Beginning: **01/01/01**Ending: **12/31/01****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	240	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(249)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(414)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,056)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	569			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,910)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(222,346)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (222,346)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (224,256)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
THREE SPRINGS LODGE NURSING HOME

Page 5A

ID# 0028472
Report Period Beginning: 01/01/01
Ending: 12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	LINE 29 DETAIL OF OTHER ADJUSTMENTS	\$	1
2	ELIM 1 YR OF 2 YR IDPH LICENSE PD 2001	(200)	20
3	DEFERRED PAINTING AMORT. SCHXIX	769	6
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	569	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME

0028472

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(249)	0	0	0	0	0	0	0	0	0	0	(249)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	769	0	0	0	0	0	0	0	0	0	0	769	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	520	0	0	0	0	0	0	0	0	0	0	520	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,256)	0	0	0	0	0	0	0	0	0	0	(2,256)	20
21	Clerical & General Office Expenses	(414)	0	0	0	0	0	0	0	0	0	0	(414)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,670)	0	0	0	0	0	0	0	0	0	0	(2,670)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,150)	0	0	0	0	0	0	0	0	0	0	(2,150)	29

Summary B

Facility Name & ID Number	THREE SPRINGS LODGE NURSING HOME	#	0028472	Report Period Beginning:	01/01/01	Ending:	12/31/01
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
IRENE WELGE	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	30 DEPRECIATION	\$	IRENE WELGE	100.00%	\$ 14,106	\$ 14,106 1
2	V	34 RENT	252,000	IRENE WELGE	100.00%		(252,000) 2
3	V	33 R E TAXES		IRENE WELGE	100.00%	15,548	15,548 3
4	V						4
5	V						5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 252,000			\$ 29,654	\$ * (222,346) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	KENNETH ROWOLD	ADMINISTRATOR	ADMINISTRATIVE	0.00	0	40	100.00	SALARY	\$ 72,119	L17/CI	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 72,119		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME # 0028472 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	NONE						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME**# **0028472** Report Period Beginning: **01/01/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 15,548	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 15,548	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 15,548	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996	12,195	8
	1997	15,139	9
	1998	15,311	10
	1999	15,479	11
	2000	15,548	12

FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THREE SPRINGS LODGE NURSING HOME COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0028472

CONTACT PERSON REGARDING THIS REPORT ROGER BAGLEY

TELEPHONE (618)549-8331 FAX #: (618)549-0133

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-162-006-50</u>	<u>231/20 PT SW SW 3.0 AC</u>	\$ <u>15,548.26</u>	\$ <u>15,548.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>15,548.26</u>	\$ <u>15,548.26</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 21,580

B. General Construction Type:
 Exterior
 MASONRY
 Frame
 STEEL & MASONRY
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME IS ON			\$	1
2	OWNER'S FARM LAND				2
3	TOTALS			\$	3

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME**# **0028472**

Report Period Beginning:

01/01/01

Ending:

12/31/01**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	11
4	83		1972	1972	\$ 433,938	\$	40	\$ 10,848	\$ 10,848	\$ 319,110	4
5			1972	1972	225,462		20			225,462	5
6			1972	1972	7,170		10			7,170	6
7			1982	1982	22,500		20	1,125	1,125	21,938	7
8			1972	1972	(24,888)					(24,888)	8
Improvement Type**											
9		LANDSCAPE & SPRINKLER		1975	2,335		20			2,335	9
10		VARIOUS(PARKING LOT, SPRINKLER, NURSE CALLS)		1976	6,814		10			6,814	10
11		PARKING		1972	892		3			892	11
12		REMODELING/LAUNDRY REMODELING		1974	1,956		10			1,956	12
13		REMODELING		1975	413		10			413	13
14		OIL & CHIP DRIVE		1978	605		5			605	14
15		ELECTRICAL		1973	399		20			399	15
16		FREEZER/BOILER		1981	10,608		10			10,608	16
17		SHOWER WALLS		1982	7,728		10			7,728	17
18		SHOWER WALLS		1983	9,279		10			9,279	18
19		PUMPS & EXHAUST		1984	3,032		10			3,032	19
20		FREEZER REPAIRS		1986	1,104	4	10		(4)	1,104	20
21		1 ROOFTOP A/C UNIT		1987	9,372		10			9,372	21
22		TELEPHONE SYSTEM		1987	2,794		20	140	140	2,030	22
23		STORAGE SHED		1988	11,422	363	20	571	208	7,709	23
24		LANDSCAPING		1988	1,998		10			1,998	24
25		INTERIOR DECORATING		1990	11,575	367	15	772	405	8,878	25
26		SMOKE DETECTORS		1990	1,764		15	118	118	1,357	26
27		CUBICLE TRACK		1990	3,804	121	20	190	69	2,185	27
28		DRAIN LINES ON DOWNSPOUTS		1990	928	62	15	62		713	28
29		CONCRETE PAD		1991	2,088	139	20	104	(35)	1,092	29
30		ROOFTOP A/C UNIT		1991	18,780	596	10	939	343	18,780	30
31		NEW ROOF		1991	60,596		20	3,030	3,030	31,815	31
32		SHOWER ROOM RENNOVATIONS		1992	5,465		15	364	364	3,458	32
33		ADDITION TO PHONE SYSTEM		1992	538		20	27	27	256	33
34		REMODEL PATIENT ROOM		1993	3,666	94	15	244	150	2,074	34
35		HOT WATER HEATER		1994	2,870	128	15	191	63	1,433	35
36		PARKING LOT REDONE		1995	21,259	1,417	15	1,417		9,211	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	PARKING LOT BUMPERS	1996	\$ 654	\$ 44	15	\$ 44		\$ 242		37
38	INSTALL CEILING FANS	1996	1,149	101	5	114	13	1,149		38
39	REPAIR SEWER LINE & REPLACE KITCHEN SINK DRAINS	1997	3,112	216	15	207	(9)	932		39
40	TILE DINNING ROOM	1998	628	78	15	42	(36)	147		40
41	SEAL & STRIPE PARKING LOT	1999	1,764	252	7	252		630		41
42	REPAIR EXISTING WATER LINE	2001	4,057	135	15	135		135		42
43	PUT ROCK & EDGING AROUND BUILDING	2001	2,661	133	10	133		133		43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 882,291	\$ 4,250		\$ 21,069	\$ 16,819	\$ 699,686		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 104,537	\$ 2,380	\$ 12,340	\$ 9,960	VARIOUS	\$ 55,043	71
72	Current Year Purchases	13,585	13,585	1,152	(12,433)	VARIOUS	1,152	72
73	Fully Depreciated Assets	114,333				VARIOUS	114,327	73
74								74
75	TOTALS	\$ 232,455	\$ 15,965	\$ 13,492	\$ (2,473)		\$ 170,522	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,114,746	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,215	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,561	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,346	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 870,208	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	ADDITION OF LAUNDRY,	\$ 4,998	92
93	DINING ROOM, AND		93
94	OFFICES		94
95		\$ 4,998	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 114

Description: STORAGE

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. <u>we only hire trained aides</u>	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3	hrs	\$	213	\$ 12,906	\$	213	\$ 12,906	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		82	5,725		82	5,725	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		292	18,118	376	292	18,494	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				10,020		10,020	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	medical supplies, oxygen, tubefeeding, Other (specify): and iv supplies	39/2					27,291		27,291	13
14	TOTAL			\$	587	\$ 36,749	\$ 37,687	587	\$ 74,436	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 91,808	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	436,133		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	216,764		5
6	Prepaid Insurance	2,250		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): TAX DEPOSITS	2,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 748,955	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	122,431		15
16	Equipment, at Historical Cost	235,787		16
17	Accumulated Depreciation (book methods)	(298,752)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): construction in progress	4,998		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,464	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 813,419	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 30,361	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,404		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,507		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401K LIABILITY	12,571		36
37	SALES TAX PAYABLE	250		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 97,093	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 97,093	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 716,326	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 813,419	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 727,910	1
2	Restatements (describe):		2
3	2000 TAXES	(1,745)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 726,165	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(9,839)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (9,839)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 716,326	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number THREE SPRINGS LODGE NURSING HOME

0028472

Report Period Beginning: 01/01/01

Ending:

12/31/01

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,235,915	1
2	Discounts and Allowances for all Levels	(30,311)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,205,604	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	81,870	6
7	Oxygen	12,989	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 94,859	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,295	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,295	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,312,758	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	507,696	31
32	Health Care	971,356	32
33	General Administration	451,337	33
	B. Capital Expense		
34	Ownership	272,329	34
	C. Ancillary Expense		
35	Special Cost Centers	74,436	35
36	Provider Participation Fee	45,443	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,322,597	40
41	Income before Income Taxes (line 30 minus line 40)**	(9,839)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (9,839)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation. **NO TAXABLE INCOME**

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME**# **0028472**Report Period Beginning: **01/01/01**

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,904	2,082	\$ 46,355	\$ 22.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,311	7,197	141,351	19.64	3
4	Licensed Practical Nurses	12,294	13,752	202,963	14.76	4
5	Nurse Aides & Orderlies	45,862	49,703	443,346	8.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,388	3,786	36,984	9.77	8
9	Activity Director	3,259	3,477	39,467	11.35	9
10	Activity Assistants					10
11	Social Service Workers	1,325	1,535	18,059	11.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,958	2,158	30,939	14.34	14
15	Cook Helpers/Assistants	10,614	11,417	102,014	8.94	15
16	Dishwashers					16
17	Maintenance Workers	1,978	2,127	23,041	10.83	17
18	Housekeepers	7,541	8,362	73,598	8.80	18
19	Laundry	4,317	4,845	45,853	9.46	19
20	Administrator	2,032	2,080	72,119	34.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,848	1,945	22,299	11.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,631	114,466	\$ 1,298,388 *	\$ 11.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	123	\$ 5,900	1/3	35
36	Medical Director				36
37	Medical Records Consultant		600	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	44	550	10/3	39
40	Physical Therapy Consultant	145	8,495	10A/3	40
41	Occupational Therapy Consultant	5	241	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	395	10A/3	43
44	Activity Consultant	42	2,160	11/3	44
45	Social Service Consultant	42	2,160	12/3	45
46	Other(specify)				46
47	PURCHASING CONSULTANT		1,175	19/3	47
48	BILLING CONSULTANT		2,776	19/3	48
49	TOTAL (lines 35 - 48)	407	\$ 24,452		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **THREE SPRINGS LODGE NURSING HOME**

0028472

Report Period Beginning: 01/01/01

Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
KEN ROWOLD	ADMINSTRATOR	0	\$ 72,119	Workers' Compensation Insurance		\$ 35,227	IDPH License Fee		\$ 400		
				Unemployment Compensation Insurance		7,035	Advertising: Employee Recruitment		570		
				FICA Taxes		99,327	Health Care Worker Background Check (Indicate # of checks performed 13)		156		
				Employee Health Insurance		8,312	DON ASSOC(85) SUBSCRIP(407)		492		
				Employee Meals		9,829	NAGNA(2233) CORP FEE(50)		2,283		
				Illinois Municipal Retirement Fund (IMRF)*			PUBLIC RELATIONS & OTHER ADV(ELI		2,056		
				401K CONTRIBUTIONS		16,693					
				BONUSES		80					
				PARTIES,X-MAS,VACCINES, ETC.		10,192					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
\$ 72,119											
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$								
C. Professional Services											
Vendor/Payee	Type		Amount								
M.E.S.	PURCHASING CONS.		\$ 1,175								
NCS HEALTHCARE	BILLING SERVICE		2,776								
ADP	PAYROLL SERVICE		494								
MIKRON	COMPUTER SERVICE		929								
JACK LINK	ACCOUNTANT		500								
JAMESTOWN MGMT	MANAGEMENT		127,275								
BENEFIT PLANNING CONS.	401K SERVICES		2,489								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 135,638								
									</		

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING	1995	\$ 5,847	3	\$ 974								
2	PAINTING	1996	2,585	3	862	430							
3	PAINTING	1997	3,549	3	1,183	1,183	591						
4	PAINTING	1998	1,962	3	327	654	654	327					
5	PAINTING	1999	6,837	3		1,140	2,279	2,279	1,139				
6	PAINTING	2001	2,205	3				368	735	735	367		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 22,985		\$ 3,346	\$ 3,407	\$ 3,524	\$ 2,974	\$ 1,874	\$ 735	\$ 367	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 8 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 45,443
This amount is to be recorded on line 42 of Schedule V. _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions. _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 9,829 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees. _____

THREE SPRINGS LODGE NURSING HOME INC.
 RECLASSIFICATIONS FOR PG 3&4 COLUMN 5 DPA COST REPORT
 ID # 0028472
 12/31/2001

COL5 LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	9829	
2	FOOD PURCHASES		9829
	RECL COST OF EMPLOYEE MEALS		
2	FOOD PURCHASES	3490	
10	NURSING SUPPLIES		3490
	RECL FOOD SUPPLEMENTS		
22	EMPLOYEE BENEFITS	35227	
26	INSURANCE		35227
	RECL WORKER'S COMP INSURANCE		